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CONTENTS

Terms: $2.00 a Year | THE MEDICAL JOURNAL CO. Professional Building Baltimore, Md. | Index to Ads. Page ii

INDEX TO ADVERTISERS

When writing, say you saw advertisement in the MARYLAND MEDICAL JOURNAL.

LOCAL DIRECTORY

Medical Society Meetings

MARYLAND

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2. Why is health the biggest thing in life?
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SOME REMINISCENCES, REFLECTIONS AND CONFESSIONS OF A LARYNGOLOGIST.*

By John Noland Mackenzie, M.D.,
Baltimore, Md.

In responding to the courteous and flattering invitation to be with you this evening, and in casting about for a subject upon which to address you, it has occurred to me that, instead of treating you to the arid narrative or perhaps profitless discussion of some of the unsettled questions which have divided laryngological opinion now and at other times, and upon which I, and not you, should seek enlightment, I would ask you to come and live with me for a few moments in another and an earlier time, in a distant day and atmosphere, in which the grown-up virile puissant laryngology of this great age of human progress was yet in its swaddling clothes. And if in doing so I shall become personal as well as reminiscent, shall give you a chapter out of my own life and my own experience, I pray you to be charitable enough not to misunderstand me, but let me believe that my words are not addressed to the unsympathetic and critical ear of strangers, but to a little circle of friends gathered around the family fireside, where I may talk with the freedom of one who is at home, and where I feel that to many of you at least I may speak, as the ancient Roman has it, "*in loco parentis.*"

In the seventies and early eighties of the last century, the Hospital for Diseases of the Throat and Chest in Golden Square, London, was the Mecca of the vast majority of English-speaking students of laryngology, who came there attracted by the reputation and engaging personality of Morell Mackenzie, then at the zenith of his professional career. Whether they went for study elsewhere or not, sooner or later their footsteps turned to Golden Square, either for passing curious observation or more serious and continuous work. The institution itself was a model of simplicity, both in architecture and equipment. In secluded isolation, it stood in the little square in the narrow zone which separates the throbbing, restless, rushing life of the metropolis from the pov-

*Address delivered at the College of Physicians, Philadelphia, at a meeting of the Philadelphia Laryngological Society, March 7, 1916.

erty and squalor of the slums, and in a silence broken only in the daytime by the roar of Regent Street, nearby. The lower floor of the building, where most of the work of the hospital was done, consisted of a very large waiting-room, it had to be large to accommodate the then largest laryngological clinic in the world, an examination-room of ample size, but simply furnished, which, in turn, opened into a very much smaller and more private one, which was consecrated mainly to physical diagnosis. In the more capacious apartment were tables and lamps for the attending surgeons and chief of staff. The upper floor was occupied by the in-patients, and was always full. It was amid these modest surroundings, in picturesque contrast to the princely apartments and imposing apparatus of some of our modern, up-to-date laryngological establishments, that many of the men who were destined to direct the after-progress of laryngology in Great Britain and America were not taught, but learned for themselves, the first lessons of their art. I entered on my duties as chief of staff in the summer of 1870. My predecessors in office were Felix Semon, Samuel Johnston of Baltimore and Lennox Browne. I had qualified beforehand for the job, having acquired the *principia* of the subject in the old Metropolitan Throat Hospital in New York, in spare hours snatched from my service in Bellevue Hospital, and under the tutelage and inspiring example of my old friend, Clinton Wagner, one of the pioneers of the specialty in America and founder of the New York Laryngological Society. At that time, with all the enormous material at our command, there was practically no instruction given, except in the way of hasty demonstration of cases, and if the student or visitor learned anything, it was through close personal observation on his part, and not through any gigantic effort to impart knowledge on the part of the medical staff. With one or two exceptions, the latter directed their attention almost solely to the larynx and thyroid gland, and the nasal passages were only examined when in quest of a polypus or when the attention was irresistibly attracted to these organs by the horrible stench of an ozoena. The nasal cavities were practically neglected, and the only apparatus in the hospital for the treatment of their diseases consisted of a pair of forceps for the removal of nasal polypi, and a handball atomizer with a detergent solution for the treatment of ozoena or any other miscellaneous disease of the nose that might irresistibly obtrude itself upon the recognition of the medical staff.

I have said that we concerned ourselves chiefly with affections of the larynx and thyroid gland. Let me pass briefly in review our then treatment of some of these affections. Among our most frequent visitors to the clinic were cases of tuberculosis of the larynx. They literally abounded. They came by the hundreds, in striking and conspicuous contrast to the comparative rarity of this disease in the throat clinics of today. Many of them presented the classical picture first drawn by Morell Mackenzie, which we considered then pathognomonic of tuberculosis. It

should be stated here that the grouping of signs, *turban* epiglottis, pyriform aryepiglottic folds, etc., so graphically described by Mackenzie, was not considered characteristic outside of England, and I must say that in my own observation I have never seen such constancy in the ensemble or grouping of appearances, either on the Continent or in the United States. At that time much difference existed among laryngologists concerning the value of laryngoscopic diagnosis in this disease. Ziemssen was the first to deny its certainty, and subsequently Heinze, and even Morell Mackenzie, gave in their adhesion to his views. Lennox Browne, on the other hand, goes to the other extreme, or, rather, went to the other extreme, and declared that, with the exception of laryngeal growths, there is no disease of the larynx in which we may be so sure of laryngoscopic diagnosis. The partisans of both these views are too sweeping in their statements. There are many cases met with in practice in which the diagnosis must remain in doubt. I believe the case can be briefly stated as follows: The diagnosis of the lenticular ulcer, especially when single or unassociated with other tubercular lesions, is laryngoscopically impossible; even when the ulcers are multiple, and bilaterally situated on the cords or vocal processes, they can only be looked upon with suspicion in the absence of other signs of the disease. This same is true of the aphthous or diphtheritic ulcer. Even the ulceration which results from infiltration is not always typical in appearance, and may need the association of other tubercular lesions to proclaim its true nature. When infiltration in unilateral, the diagnosis is sometimes shrouded in doubt, except when multiple ulceration has taken place. The association of the turban-shaped epiglottis with the pyriform swelling of the aryepiglottic folds is characteristic of tuberculosis, and should not be confounded with edoema, its closest simulator. It should here be remembered, however, that edoema may complicate the case and cause uncertainty as to its real nature. When to the characteristic infiltration of the epiglottis and aryepiglottic folds is added the typical worm-eaten superficial serpiginous ulceration, the grouping in the picture is pathognomonic. The typical laryngeal tubercular ulcer resulting from infiltration, in its development, appearance and course does not resemble any other laryngeal disease with which I am familiar. The lesions of this—and this is true of many other diseases—may, of course, occur in atypical forms, the characteristic grouping may not be present, and the diagnosis may be left for awhile in doubt, but this does not invalidate the position that tuberculosis manifests itself laryngoscopically (in the larynx) in a manner different from any other known form of disease.

The subject may seem trite and superfluous, but I have introduced these remarks on the laryngeal picture in tuberculosis in order to emphasize the importance of the laryngoscopic or naked eye method of diagnosis (supplemented or not, as the case may be, by clinical phenomena) to the exclusion, if possible, of the

microscope and the laboratory in the detection of disease in the larynx. In these days of unquestioning reliance on and faith in chemical and other strictly scientific, as contra-distinguished from purely clinical aids in disease discovery, it is in many quarters at least fast becoming a lost art. As the introduction of the modern, direct methods of examination have done away largely with much of the old-time manual dexterity in intra-laryngeal and tracheal manipulation, so the common use of laboratory tests have, by opening up a lazier and easier road to diagnosis, greatly dulled the former diagnostic sense and diagnosite acumen. To overcome this unfortunate condition of affairs in the coming generation, the student should be shown as many cases as possible of a given malady, in order that the picture of the disease may be so photographed on his brain and embedded in his memory that he may be able to recognize it by sight alone when brought before its image in the mirror. Take him back to the old-time initiative in diagnosis, teach him to rely more upon his special senses, tell him that, after all, personal observation and clinical experience are less fallacious than the more artificial, although more strictly scientific methods, even though the latter may be, in many cases, indispensable and in some ways more exact. It is only human to make mistakes. Let him not, therefore, in case of doubt, run to the laboratory at once for help, as is the rule in most cases today, but without in the least degree underestimating its inestimable value and assistance, let him seek it as the court of last resort. In other words, let him make the diagnosis with the naked eye alone; form his opinion in this way first, even though he may have to control it in the end by scientific tests.

The student should be schooled not only in the naked-eye appearance of laryngeal disease, but also in what is even more necessary—early laryngoscopic diagnosis. The supreme and far-reaching importance of the latter ought to be evident to intuition, and the very mention of the subject in a company of laryngologists should be looked upon as a piece of gross impertinence: and yet, unthinkable and incredible as it may seem, to many workers in this special field today, whose vision does not carry beyond the tonsil, whose horizon is the palatal arcade and whose ignorance of what lies beyond it, is as boundless as the deep, it is a neglected or even unknown accomplishment. A fellow-laryngologist, an excellent man and a good surgeon, who had wasted a number of years out of what might have been a wholly useful life removing tonsils and doing submucous resection, when asked by a brother practitioner about the laryngeal appearance in one of his cases, exclaimed, "Larynx! I know nothing about the larynx!"

It is impossible to exaggerate the importance of the laryngoscope to the medical and surgical diagnostician in the early detection of disease, not only in the respiratory organs themselves, but, of equal, if not superior importance, in neighboring and remote organs of the body. Long in advance of the appearance of

classical signs and symptoms of disease in other organs it often points the way to grave disorder.

Not to multiply examples, how often is such a seemingly innocent performance as a lame or staggering cord in an otherwise apparently healthy individual the early herald of the existence of some formidable affection, such as malignant growth, central nerve disease or aneurism, or a tiny moist or weeping ulcer on the vocal process or a vegetation in the inter-arytenoid space to the alert and practiced eye the telltale, though silent, witness of tuberculosis!

Every tumor of the larynx, no matter how benign it may appear, should be examined with the greatest possible care. Some of the most fatal diseases known to man make their first appearance in the larynx in the guise of great benignity. Thus the presence of cancer and tuberculosis in the individual is often first proclaimed by the discovery of an apparently simple papillomatous excrescence in the larynx. By the careful study of *every* case coming under our observation we will some day, among other things, clear up the mystery which surrounds the genesis of papilloma and approach more closely with the naked eye alone the earliest possible recognition of some of the most deadly diseases of the larynx.

One day a man was admitted to my division in Bellevue Hospital with the diagnosis of typhoid fever, but who presented an appearance which I had never seen in that disease. Not knowing what ailed him, I called the resident medical staff in consultation, and the consensus of opinion was that, while his trouble was not such as had been diagnosticated, it was impossible to classify it, to give it a name, as none of us had ever seen its like before. Janeway was summoned. "Acute ulcerative endocarditis." In view of the fact that there were no detectable morbid heart sounds present, the diagnosis was a brilliant one, and was verified by autopsy on the following day. At that time the disease was practically unknown, certainly not generally known, on this side of the Atlantic. I had read somewhere an abstracted account of the affection, taken from a French journal, but had forgotten it. In the absence, apparently, of heart trouble, how could you possibly make such a diagnosis, he was asked. "I don't know, but I have seen a case," was his reply.

The local treatment (of laryngeal tuberculosis) consisted in the use of hot and cold soothing and stimulating inhalations, the insufflation of an opiate, generally morphia, followed by a mixture of iodoform and starch and the use of the oesophageal tube to facilitate deglutition, and our one consoling thought was that we had placed our patient in a condition in which he would suffer the minimum amount of pain and approach the end, if possible, with resignation and an equal mind. All were doomed to die; the appearance of the disease in the larynx was the warrant of death. We did not know then that some of the very worst cases could be saved. It was not until years after that I had the truth of this

latter statement brought forcibly home to me by the following case, which I take from several others quite as remarkable:

Mr. B., a small, important little man, with an iron will, came from a distant city to consult me before going West for his health. He had a good-sized cavity in the left apex; both ventricular bands were the seat of broken-down infiltration, the ulceration covering both surfaces completely and extending into the ventricles. There was marked infiltration of the aryepiglottic folds (pyriform swelling), which had, however, not yet ulcerated. Physically, he was in very bad shape; was very weak, and in no condition to undertake even a short journey. I advised him to return to his home, give up his business (that of banker) and live in the open air, and on no account to attempt his trip to the West, as he might never reach his destination alive. It was Seneca who said that it is a part of the cure to wish to be cured. Well, this little man wished to be cured, and cured at all hazards. And he therefore did not take my advice. The next time I saw him, two years later, his chest cavity had become obsolete, the laryngeal infiltration had disappeared, and the ulceration had completely healed. He had gone to Colorado, pitched his tent in the wilderness, lived in the open air, and, as far as possible, in silence and in solitude, and during the entire absence from home had taken no medicine, nor had he even laid eyes on a physician. Again, and against my advice, he returned to his former business. In six months ulceration broke out afresh in the larynx. This time I told him to take the fastest express to the West. To make a long story short, I saw him 21 years after his first visit to me. He was perfectly well, and, apart from the scars in the larynx, no one would have known that he had ever been hurt. Remember, this was not a case which happened yesterday, or the day before, but long years before man had surrendered to nature the care of tuberculous disease.

Among the cases of general and laryngeal tuberculosis which presented themselves for treatment there were a goodly company of the variety of laryngeal neoplasm, which I have called in my classification of the laryngo tracheal neoplasms occurring in that disease, papillomatous excrescences, vegetations and tumors, and which I have discussed at length elsewhere.*

As this form of tumor is yet imperfectly understood, as very little is still known concerning its histological nature, and in view of the fact that the determination of its essential character will have an important bearing on its treatment, I will again venture a word concerning it. These are the members of the second group, and are closely allied macroscopically to simple laryngeal papillomata, for which they are easily mistaken. They are the growths which every student learns to recognize in the alphabet of his special studies. They are often the *avant courrier* of laryngeal and pulmonary tuberculosis, and may remain for a long time as

*Archives of Medicine, New York, October 1, 1882, and an unpublished paper read in this College in December, 1901.

the solitary outward and visible sign of that disease. Their presence in the interarytenoid fold often furnishes strong presumptive evidence of incipient tuberculosis. They vary greatly in size, shape and situation, sometimes projecting from under the anterior commissure of the larynx in the form and appearance of a spray of coral, at others filling the larynx with growths macroscopically indistinguishable from simple papillomata, which are sometimes so abundant as to cause stenosis and necessitate tracheotomy. Their most characteristic seat is the posterior laryngeal wall, where they appear as warty acuminate or leaflike outgrowths of a pale grayish or pronounced reddish hue, or banked at that situation in a solid mound, either smooth in contour or bristling with multiple acuminate projections. The histology of this class of tumor has been imperfectly studied, and may well in the future bear a more careful scrutiny. Stoerck, who first called attention to their presence in the interarytenoid fold as an infallible sign of incipient tuberculosis, following Rokitansky, regarded it as the result of an indurated proliferation of the connective tissue which occurs in the course of chronic tubercular disease of the mucous membrane in the neighborhood of the arytenoid cartilages. Kundrat, who examined several of Stoerck's cases, pronounced them essentially papillomata and non-tubercular in origin. I know of no other special observation on the subject, with the exception of the microscopical appearances of a case of my own, examined for me by Sydney Cone, then pathologist to the surgical department of the Johns Hopkins Hospital, many years ago and reported to the oto-laryngological section of this College in December, 1904. I have not time to go into a detailed account of the anatomical report. Suffice it to say that in the sections examined the picture was that of a tuberculosis of a papilloma-papillomatous tissue infected with tubercular tissue. Whether or not the growth is originally tubercular or becomes so secondarily through infection is a point to be determined by further observation. Without going into explanatory detail, the study of the sections developed facts which were not only of histological, but also of eminently practical importance. It was especially interesting from a diagnostic point of view in the microscopic differentiation of this form of outgrowth from the papillary variety of epithelioma, particularly when as sometimes happens the tubercle bacillus is only found after a diligent and prolonged search. It also went to show that incomplete attempts at removal only served to stimulate the local growth of the neoplasm and increase the danger of reinfection. It will be the task of the future to determine whether all growths of this nature found in a tubercular subject show a tubercular structure, or whether there are some that adhere to the strictly papillomatous type. Whether benign or tubercular, the very fact that this variety of tumor often heralds the approach or proclaims the presence of tuberculosis in the individual only emphasizes the importance of examining with care not only clinically, but microscopically, all

papillomata taken from the larynx and trachea. With regard to their mode of development, it is quite possible, as Cone has suggested, that in some cases at least they may have an origin analogous to the papillomata found in the uretha and vagina, which are probably produced by infection by the tuberculous discharge from the bladder and uterus.

This variety of outgrowth was always looked upon as perfectly legitmate surgical prey. I have often removed the entire tumor or portions of it, calmly and utterly innocently oblivious of the fact that I was in so doing stimulating its local growth and scattering the disease elsewhere, thus shortening the journey of the patient to the grave. Looking back through that night of meddlesome, though innocent surgical transgression, as I view it in the long experience of after years, and fully mindful of the fact that the universal sentiment of authority counsels immediate surgical removal of all growths in the larynx of the tubercular subject, I must confess that even now I approach the consideration of their treatment with great trepidation as I give you the advice, which I gave in this College, but before another society, over 12 years ago. The mere presence of a tubercular tumor in the windpipe is not always necessarily an indication for its removal. If an operation is to be done, it should be done for good and sufficient reasons, and after weighing carefully all the facts in each individual case. Tubercular tumors of the larynx, as far as we at present know, pursue a slow course, show little tendency to early ulceration and may survive with unbroken surface the process in the lung. In their removal by ordinary methods the possible dangers of autoinfection, with metastasis and reinfection at the seat of operation, should not be lost sight of. That these dangers are not chimerical is apparent from some of the recorded literature of the subject, and notably in the case of Hennig, in which death from reinfection took place 37 days after the operation. In my own cases, two were found post-mortem, two were already past all surgery, while the fifth remained with unbroken surface for 10 years, and was not touched with instruments of any kind. Serious interference with function should, of course, constitute ground for operation, and the character of the latter will depend on the nature of the case. Whatever method of procedure is adopted, it must be radical and include not only the removal of the growth in its entirety, but also a liberal portion of the surrounding healthy tissue. A closer study of tubercular tumors of the larynx will be necessary before we can formulate a definite plan of surgical treatment. In the meantime, we must watch and wait.

Out of all the joyous hours at Golden Square that still linger affectionately in my heart and in my recollection, there comes to me but one disturbing and discordant memory—our treatment of cancer of the larynx. This consisted, I shudder in the telling, in the performance of tracheotomy, and the subsequent removal, piecemeal, of the growth through the natural passages.

By this process, which today in enlightened surgical communities would be considered as a means of slow murder, the growth was stimulated at once into much greater activity; the patient naturally became worse and worse, and was sent to his long home much earlier than if he had been left severely alone. Of course, there was never a thought of cure. The patient was passed around from surgeon to assistant, and from assistant to student, each in his turn removing fragments from the larynx. One of the visitors to the clinic said, on one occasion, of a case thus maltreated, "Look at the poor devil; he has been plucked at by every expert and tyro in the place!" Naturally, the more the forceps were used, the more desperate became the plight of the patient. These were in very truth the days of frightfulness in the management of this disease. As I have often said since then, when I look back through the years in which I have seen cancer of the larynx maltreated, and in which I have unconsciously maltreated it myself, I am simply appalled at the retrospection. With the accusing voice of those days of sacrifice and slaughter still ringing through my mind, and in full view of the chastening experience of succeeding years, I trust that in the long and bitter fight that has raged around the treatment of cancer of the upper air tract during the last two decades I have at least in part atoned for the sin of my youthful experience, although I have been held up as a still greater transgressor for demanding in all cases of larynx cancer the most radical measures, and for keeping hands off the growth until the last. Just here permit me to correct a wrong impression that seems to have been created in the minds of some of my colleagues both at home and abroad as to my views on microscopic evidence in the diagnosis of suspicious looking neoplasms of the larynx. According to my critics, I reject completely the use of the microscope in the diagnosis of malignant growths of the larynx, and therefore would recommend the complete operation for that disease in the presence of doubt as to its nature. As one of them puts it, I "kick the microscope into the dust heap." No one but a congenital fool would refuse in doubtful cases the aid of the microscope, and no one outside of an asylum would advise a radical operation (such as the one suggested by me) without a certainty of diagnosis. There are some things that go without saying and which ought to be obvious to the dullest apprehension, and I cannot think that anyone who knows me can believe me guilty of such insanity. My original remarks made in 1900, which have called forth such a storm of abuse and misrepresentation, dealt in general principles of diagnosis, and no attempt at elaboration or specification was made. My position, as then stated, is simply that the microscope should be the court of last resort—the final method of appeal. Hands off the growth until the last. Then, if microscopic examination is necessary, let patient and surgeon be prepared for immediate operation. As I said on the occasion already referred to, "before resorting to thyrotomy as a diagnostic means in general, especially if a portion

of the growth is to be removed for examination, it should be clearly understood beforehand with the patient that, if the disease should prove to be cancerous, the surgeon shall be at liberty, if in his judgment it seems best, to proceed at once to operation." I took this stand in order to check, if possible, the reckless and indiscriminate removal by laryngologists of suspected tumors of the larynx for microscopic examination, and from what I hear and read I may be pardoned if I say that the warning has not been given in vain.

As these remarks are devoted to reminiscence and confession, and not to controversy, a discussion now of the subject would be entirely out of place. As I leave it, let me turn to the last words on larynx cancer by Butlin, the inspiration and leader of the English school, uttered not long before he died. "I wish I had begun to perform it (laryngectomy) earlier. I am sure that several of the cases in which I performed thyrotomy were much better fitted for laryngectomy, and I cannot help thinking I might have saved one or two of the patients in whom recurrence took place if I had then removed the larynx. I think the glands ought to be removed in every case in which there is extensive carcinoma of the larynx, even if it be intrinsic, unless the disease is limited to the middle zone of the interior of the larynx. Even in these cases it would probably be a wise precaution to remove the glands. I have never removed the glands and the larynx at one sitting."

Catarrhal affections of the larynx were treated with inhalation, insufflation, and topical applications were made to that organ with the camel's hair brush, the use of compressed air being then unknown in England. Our main reliance was on the salts of zinc, the chloride and the sulphate in simple, and the sulphate of copper in syphilitic laryngitis, and I may say in passing that there are few, if any, agents that surpass in efficacy in simple inflammation of the larynx these preparations of zinc, which are among our oldest and most trustworthy servants in the treatment of this class of affection. Among the ward formulae in Bellevue Hospital was one which we greatly relied upon in the treatment of venereal warts, and which consisted of a solution of sulphate of zinc in spirits of lavender. When this was applied to the growths, they vanished as if by magic. So striking was the astringent effect that when I started in practice I had a more elegant preparation of the zinc salt made, which I have been using successfully ever since.

Comparatively little was known at that time of affections of the thyroid gland. All cases were alike to us—all were goitre. The treatment consisted either in drawing a seton through the tumor or embedding in its substance a dart of zinc shaped like the point of an Indian arrow and inserted into the body of the growth through a liberal opening with the knife. Profuse suppuration was thus set up, which after a lapse of more or less time, and after much inconvenience and suffering, caused, or did

not cause, diminution in size or virtual disappearance of the growth. A photographic album was kept in the clinic with life-like pictures, which preserved the images of the patients in the various stages of their martyrdom.

Turning now to diseases of the nose (rhinology), we find that, with the exception of polypus and ozoena, it was practically a closed book. Even with deflection of the septum (can you think it?) we had no concern. The same was true of the accessory sinuses. In the second volume of Morell Mackenzie's classical work, published as late as 1884, in the section on nasal diseases, the subject is not even mentioned. Even the antrum was overlooked, in spite of the fact that centuries before, Drake and Cowper, and the two Meibomii (father and son), had lent their influence to the necessity of the investigation of antral diseases, and to the surgical methods for their relief. And Palfyn, in the seventeenth century, had called attention to frontal sinus suppuration, and proposed the trephine for its cure. All that I knew about the sinuses was contained in an article by Sir William Hamilton in the *Medical Times,* 1845, and familiar to me in my college days through its reproduction in an appendix to his well-known work on Metaphysics. In this curious contribution he sought to combat the dogmas of phrenology by showing, among other things, that the frontal sinuses were the natural abodes or hiding places of many different kinds of worms and other low forms of life.

The motley multitude of its guests might almost tempt us to regard it as

> "The cistern for all creeping things
> To knot and gender in."

Much confusion existed in those days of the sixteenth and seventeenth centuries as to the source of purulent discharges from the nose, some considering them all of cerebral origin, others declaring that those which were not attended with fever, headache or pain elsewhere, and from which the pus flowed from the nostrils without inconvenience to health, as in a suppurating ear, came from what was known then as the pituitary sinuses. Nathanael Highmore, who wrote at that time, and whose name has been preserved from oblivion by his graphic account of the antrum maxillare, did not help the existing confusion much when he declared that the ostium maxillare which he described and depicted, was an immisary, and not an emmisary, foramen of that cavity. Hence those who followed him described pain in the teeth and caries as due to a "humor distilling from the head into the antrum of "Highmore," thus getting the cart well in front of the horse. Let me remind you here that in the ancient Greek systems of medicine all nasal discharges, whether catarrhal or suppurative, were supposed to come from the brain, through the cribriform plate, ethmoidal and sphenoidal cells, according to Hippocrates; from the pituitary gland and ventricles, according

to Galen. These views of the Greek physicians, whose notions of the etiology of disease were curiously influenced by the prevailing philosophical doctrines and vagaries of their time, were followed by the Arabian school, and were imported by them into Europe, and prevailed on the Continent as late as the seventeenth century, when they were completely overthrown by the colossal labors of Conrad Victor Schneider, whose wonderful anatomical picture of the nasal mucosa led Haller to christen it the Schneiderian membrane. It is true that Van Helmont had long before assailed with pitiless satire the "gray-haired dreams of the Grecians"; that Cardan had previously shown that the discharge came sometimes from the secreting portions of the nasal membrane, and that Botal had entered an anatomical protest against the hypotheses of the ancients, but it is chiefly due to the exhaustive anatomical researches of Schneider that their absurdity was demonstrated. Schneider's demonstrations imparted a great impetus to the study of the anatomy and surgery of the head. Morgagni laughed at Highmore's blunder, but conspicuous among the surgeon anatomists of his day it was William Cowper, who was the pioneer, and who shed most light on its differential diagnosis and treatment, and made sinus suppuration give up the secret which it had kept so long.

But in spite of the fact that the subject had a literature running back to remote or even ancient times, it was not until the great grippe epidemic in the declining days of the century that has recently passed away that man first awoke to the full realization of what a curse his sinuses had been to him (and he, too, all unconscious of the fact) throughout all the centuries that had gone before. At that time, while we had made great advances in technique, while the dawn of a new era in this class of affection was breaking, it must nevertheless be confessed that we followed very closely the teachings of our masters of long ago.

In 1894, at the Congress of American Physicians and Surgeons, the subject of accessory-sinus disease was given prominent place, for the first time in this or other countries, before a general medical and surgical audience of the entire society. Bosworth, Bryan and I were assigned to the task of opening the debate. The following year the first international discussion of the subject of the surgery of the sinuses was held in London at a special and unusual session of the British Laryngological, Rhinological and Otological Association. Those who took part in it and gave their views and experiences were Bosworth, Luc, Delavan, Moure, Lennox Browne, Daly, Mayo Collier, DeRoaldes, Dundas Grant, Krause, Bryan, Bark, Sajous, McIntyre and Stoker. For some inscrutable reason I was asked to open the debate. The remarks of those who followed me were most instructive, and for that day a fairly thorough exposition of the then status of the question. I mention these two occasions, for they were among the early signals for the onrush of the coming events in this special department of surgery, which had already cast their shadows

before. The ball had started to roll, the pot had commenced to boil; the worst was yet to come.

No, I shall not disturb the tonsil question. God forbid! I am down in cold, remorseless type in many places on that subject, and even if I wished to run away from my convictions, I would have no avenue of escape. I only want to say that those far-off days at Golden Square were perhaps the tonsils' happiest and most halcyon time; for it had not then been found out that the germs of a multitude of diseases common to man left well-established, convenient and natural avenues of entrance into the body to seek their destination by other and more devious paths through the tonsil substance; nor had this invading host of pathogenic visitors, some well known, others nameless and nondescript, yet found in the tonsil crypts and in the tonsil vessels either a birthplace or an asylum. They fell; yes, fell as leaves in Vallombrosa. Not a day passed that did not take its bloody toll of tonsils. The guillotine was nearly every day much the busiest instrument on the job. In all that long roll of cases I fail to recall a single serious accident after tonsillotomy, except now and then severe hemorrhage; nor have I even seen since then the operation done with more dexterity and thoroughness. If the surgeons of those days did not do as much far-reaching good as the tonsillectomist of the present time, they certainly did infinitely less harm.

One of the strangest things in the early development of rhinology in England and America was the slow and belated perception of the importance and significance of the condition falsely known as adenoids. Although over 10 years had elapsed since the publication of Myer's work on the subject, and although two years later it had been translated into English in the transactions of the Medical and Chirurgical Society of London (1870), very little attention was given to it in the clinic. Woakes and I operated on a great many cases. Woakes wrote a paper in which he maintained the papillary nature of the growths against the generally accepted belief that they were glandular or adenoid in structure. We never knew our mistake until French had to tell us that they were neither papillomatous nor adenoid, but lymphoid in character. Woakes was an interesting personality, with original, but often erroneous, theories. His work on "Necrosing Ethmoiditis," while pathologically hopelessly wrong, served to first rivet attention on the study of ethmoiditis, and was therefore historically the beginning of the modern literature of that affection.

In looking back to the old days in London, allow me to recall yet another experience, which to me at least has a certain historical interest. One morning I received a visit from a friend and fellow-lodger in the house in which I had, as the English say, "chambers." He was a phlegmatic Dutchman, a born linguist (spoke seven or eight foreign languages fluently), a globe-trotter, an observer of a most inquiring and eager mind. He had come to consult me about a coryza which invariably and only

occurred after sexual indulgence. I told him that he must be dreaming, or that he must catch cold during the sudden cooling off process following the heat of tempestuous bodily exertion. Not at all. He did not get unduly excited at the time. On the contrary, he was more or less indifferent to coitus, but practiced it one day a month as a physiological duty (or purge), as a matter, as it were, of personal hygiene. It was a part of his philosophy. One night during the month coitus, the following morning always coryza.

The situation was unique, interesting, absolutely new to me and others to whom I told the tale. Shortly after this experience I stumbled quite by accident in the clinic on two women who complained of stoppage of the nose, sneezing and watery discharge, occurring only during the menstrual period. Not to delay you with a longer recitation of the circumstances in the case, without a guide, in an absolutely unknown territory, coming across an observation here and there and ever on the alert and looking for cases bearing on the subject myself, at the end of five years I had accumulated enough material from which to generalize and publish my conclusions, which I did in the *American Journal of the Medical Sciences* for April, 1884, in an essay which was the first attempt to reduce this curious relationship to a scientific basis. This, then, is the simple story of the almost accidental discovery of a then unknown physiological relationship which today has an enormous literature. Two years ago I received from Germany a work by the younger Seifert, which consisted of a critical review of nearly 300 brochures, theses and papers on the subject, and even this list of contributions was incomplete.

From London I went to Munich, where I became an assistant in the clinics of Zeimssen and Oertel. Zeimssen was a prolific writer, but is chiefly known to laryngologists as the author of the articles on diseases of the larynx in his well-known Encyclopaedia of Medicine. Oertel wrote little or nothing on laryngology, but his articles on the physics of laryngoscopy were the most scientific of his day. Zeimssen, a tall, distinguished patrician type of man of advanced years; Oertel, a little hunchback dwarf of middle age, but whose face was intelligence itself, and whose eye was as piercing as the Roentgen ray. Both masters of internal medicine, both experts in laryngology.

Although a comparatively small town, the wealth of clinical material in Munich was enormous. I have never seen in a given period of time, not even in the vast clinics of London, such a number of laryngeal growths, nor have I ever seen them removed with greater skill. They came to Oertel from all parts of the Continent, and the little man, even in the most difficult cases, always made good. For the student the atmosphere was ideal, the combination of special and general work perfect. At one moment we were giving cold baths or packs to typhoid patients, in the next removing a laryngeal growth. The special branch of medicine was not studied apart, but kept in contact and closest

touch with all the other departments of medicine. We could not get away from any one part of general medicine even if we wished to do so, and this leads me to say that the proper time to lay the foundation for the educated specialist is in early life, in his early studies, if possible in his undergraduate days, for it is at this period of his medical training that he is in the best position to acquire that fundamental knowledge, and, what is of more importance, that breadth of mind which is so essential to his future development. At this receptive period of the development of his mind he can best recognize the limitations of each special branch of medicine, and can best be taught to generalize profoundly not in one, but in all departments of medical thought. It is at this stage of his career that it is impossible for him to cut loose from the other departments of medicine. The growth of his special studies goes on *pari passu* with his advance in other lines of work, and he is brought in daily contact with disease in other organs of the body. He learns at the outset that no department of medicine is isolated and independent, but that they are all mutually dependent and co-ordinate. And if he is made of the proper stuff, this fundamental lesson and illuminating first impression will follow him in his special work in after life as an inspiration and a guiding star.

Those days in Munich were halcyon days. I thank my stars that I lived and learned in the older Germany, before that nation had altogether ceased to be the dreamer that she was when she entered the modern world; that I heard her music and listened to her songs in the joyous, peaceful days of the Lorelei, and not in those of the Hymn of Hate; before the departure from simplicity and simple idealism of the lovable people who gave the world Santa Claus.

Later, when I studied in Vienna, I found a different atmosphere. Here the only means of acquiring special knowledge of the subject were the imperfect courses on diseases of the larynx given by the professors and their assistants. There was no special course in rhinology, which subject, as in England, was left entirely alone. Stoerck and Schroetter were the leaders in laryngology at that time. The former, although handicapped somewhat by his method of examination, the so-called Schusterkugel, and a trembling hand in manipulation within the larynx, always delivered the goods. Hans Chiari, then assistant in pathology, now professor in Strassburg, had charge of the department of pathology in the Rudolfspital. He had five young men to help him in the laboratory, three of whom were Americans—Councilman, now of Harvard; Belfield of Chicago, and myself. It was one of my duties at the autopsies to look after the condition of the larynx and trachea, so that when one morning the body of a man who had died of cancer of the stomach was brought in for a post-mortem, I was handed the windpipe for examination. Secondary cancerous deposits were present in the liver, kidney, spleen and other organs.

The lungs, however, contained tubercular cavities; the pharynx, larynx and trachea were free from inflammation and ulceration. The bronchial and retrotracheal glands were enlarged, tumefied and caseous. In the membranous posterior wall at its junction with the cartilaginous framework of the trachea, about 1½ cc. above the bifurcation, was a well-defined circumscribed tumor about the size of a small bean, its long axis parallel with that of the trachea, and of a uniformly even, smooth appearance. It was covered by the mucous membrane of the trachea, and was dense in consistence, giving to the touch the sensation of a hard cancerous nodule, for which, indeed, it was mistaken. A similar growth was found in the pericardium. The microscope revealed a picture for which I was not prepared. It showed, namely, that the tumor, which seemed to have its origin in the submucous connective tissue, consisted in the main of an aggregation of distinct tubercular nodules, set in a more or less well-marked vascular network of connective tissue. The majority of the tubercles lay in the deeper portions of the mucous membrane and in the submucous tissue. A few were more superficial, lying under the epithelium. They exhibited all grades of degenerative change; in some caseation was so far advanced that nothing remained but the cellular wall. Between the individual nodules the connective tissue was hypertrophied and the seat of a moderate amount of round-celled infiltration, which had invaded the glandular follicles in its vicinity. The tissue of the trachea in the immediate neighborhood of the growth presented no remarkable change. The nodule in the pericardium showed the same histological structure that was found in the tracheal neoplasm. Shortly after this experience I came across a similar case, in which the tumor was confined in a most unusual way to the vestibule of the larynx. The subject from whom the growth was taken died of pulmonary tuberculosis. The whole upper compartment of the larynx, including the epiglottis, aryepiglottic folds and ventricular bands, presented a remarkable appearance. It was completely covered by little mounds, which represented small, uniformly smooth, dense, moderately hard nodular growths, which lay beneath the mucous membrane. The nodules were about the size of a split pea, each merging into its neighbors, so as to form one continuous growth. The process ceased abruptly on either side at the free border of the ventricular band. There was no trace of ulceration in pharynx, larynx or trachea. Microscopic examination of numerous sections of the growth showed it to be of the same nature as the above-described neoplasm in the trachea. These two cases were absolutely unique. Chiari had never seen anything like it before; no one had even suspected the existence of such a condition. After over a year's search through literature for similar cases, I published my own in the *Archives of Medicine*, New York, for October 1, 1882. As much confusion still exists as to what constitutes a true tubercular tumor of the windpipe, I may be pardoned for again drawing attention to the

subject. Since the publication of my own, cases have here and there found their way into medical literature, some without doubt examples of true tubercular tumor as defined in my original article, whilst others—and these are probably in the majority—are extremely doubtful in nature, and must be thrown into the category of localized infiltration or into the papillomatous group, which I have already considered. A true tubercular tumor is extremely rare, and by true tubercular tumor I mean not simply any localized swelling containing the bacillus, but a distinct, definite characteristic tumor formation covered by unbroken epithelium and consisting of a congeries of miliary tubercles set in a vascular network of connective tissue and exhibiting all grades of tubercular degeneration to cavity formation. I have seen but three cases in which the diagnosis was microscopically established beyond a doubt, and two in which no histological examination was made. As far as my limited experience goes, the tendency of this form of tumor as well as the papillomatous variety is not toward ulceration unless tampered with by incautious attempts at instrumental removal. In one case, in which the patient made a gallant fight for life of nearly 10 years and finally succumbed to pulmonary hemorrhage, the growth, which consisted of a small, smooth lobular tumor in the interaryitenoid fold, during that whole period, beyond a slight increase in size, remained practically unchanged. These two cases are of historical interest, inasmuch as they are the first cases on record of tumors of any kind in the windpipe shown microscopically to be tubercular. They therefore represent the earliest exact knowledge of this form of tuberculosis, and are the first to establish the separate existence of this previously unknown phase of that disease.

As in London, so in Munich and Vienna, no attention was paid to the nasal passages or accessory sinuses, and therefore no courses on the subject were given. I had to turn my steps homeward to learn something about the diseases of these organs. Here, too, I entered a practically untrodden field. The subject holding the center of the stage and overshadowing every other at that time was the surgery of the turbinated bodies, and especially the inferior, in the treatment of the hypertrophic form of rhinitis, and the operation engaging most attention was the removal with the cold wire snare of the posterior hypertrophied end of the inferior body for the relief of that condition. Although these masses were probably removed again and again with the wire, as anyone can convince himself by referring to the standard surgical works of the last two centuries, their true anatomical significance and relation to nasal inflammation was not properly appreciated until Bigelow demonstrated the erectility of the tissues concerned in their development. As I have pointed out elsewhere.* Bigelow was not the first to show the erectility of that

*Boston Medical and Surgical Journal, January 1, 1885.

structure, but to him, apart from independent discovery, belongs the credit not only of giving the best description of this tissue, and of more accurately defining its minute structure and extent of distribution, but also of showing that the so-called muco-periosteum of the posterior part of the septum is in reality an erectile substance. Bigelow was also the first to observe the alternate inflation and collapse of these bodies, which he compared to that of the lungs of a small animal, thereby leading the way to the rational interpretation of nasal inflammation. From their resemblance to the cavernous bodies of the penis Bigelow gave them the name of turbinated corpora cavernosa, but as Henle and, more recently Zuckerkandl, have pointed out, they may be with more propriety classed among the contractile as contra-distinguished from the erectile tissues.

The credit of urging the necessity of their removal by the cold wire snare belongs to Jarvis. Prior to that the galvano cautery had been used in this country and Germany. In the latter country it was extensively adopted, and it is a noteworthy fact that Zaufal, who is an enthusiastic advocate of the cold wire snare in the removal of polypi, recommends the cautery for turbinated hypertrophies. Jarvis was followed by Bosworth, who wrote enthusiastically upon the subject. I wrote about it, everybody wrote about it, and everybody operated. One of my colleagues said that, on leaving my office one day, he trod on what he thought was a lot of peanut shells, but on picking some of them up he found that they were turbinated bones. The operation in the course of time was abandoned. The operators went to the other extreme, as in the case of all surgical crazes. The operation, however, within proper limits did much good, for the following reasons: In cases suitable for it, it fulfilled in a simple and radical manner the removal of the obstruction, and it did this without interfering with the normal air currents in their curvilinear course through the middle meatus, as that avenue and the anterior portions of the passages remained unchanged in their anatomical relation, thus preserving intact normal respiration and natural filtration of the air. As the hypertrophied mass meant tissue largely deprived of function from the loss of glands and blood vessels, their absence involved no sacrifice of physiological usefulness, while their removal not only facilitated cleansing of the posterior nares, but also diminished apparently the amount of tenacious mucus which they contributed to the nasal discharge. It also seemed to relieve the collateral congestion in other parts of the cavernous structure. Finally, in some cases it caused the complications of so-called reflex character to disappear, especially cough and asthmatic breathing. The latter is easily understood when we reflect that it is this portion of the reflex sensitive area of the nose that is most responsive to reflex

producing impressions, notably those concerned in the production of cough and asthma.*

The simple removal of the posterior end, leaving the rest of the structure intact, is a safer and much more rational procedure than the wholesale destruction of the turbinated bodies, which is the routine practice so common at the present day of those who forget that the aim of nasal therapeutics is preservation of function, and not the destrucion of everything in sight. Let me repeat in this connection what I have said upon another occasion:

No one questions the frequent necessity of the complete or incomplete sacrifice of the middle turbinate bone, notably in the case of accessory sinus suppuration and the radical cure of tumors of the nasal and accessory cavities, and, in occasional cases, as a substitute for operation on the septum. But to make it responsible for a host of woes unnumbered, and to attack it surgically from a purely theoretical standpoint, is vicious both in principle and practice. Especially preposterous is its removal for the alleged cure of the disease falsely called hay fever. In dealing with this structure, it should always be remembered that its anterior end is one of the chief buttresses against the admission of foreign matter to the air passages, the principal point at which filtration of the external air takes place. It should, therefore, not be assailed on indifferent and insufficient pretext, or sacrificed on the altar of fantastic hypothesis.

One of the most interesting, if at the same time one of the saddest, chapters in the books of rhinology is that which tells the story of the surgery of the septum. In the early days of my special practice, comparatively little had been done to radically and satisfactorily remedy abnormalities of that structure; observers busied their brains with the burning question whether the deflected septum is turned more frequently to the right than to the left, never concerning their faculties with the remedial

*The effects or sensations produced by irritation of the nasal mucosa, whether by mechanical, simple tactile or electric contact, chemical or thermic agencies, or by a pathological process, are more correctly appreciated and located in the anterior than in the posterior portions of the nasal passages. The more we recede into the deeper regions, the nearer we approach the pharynx, the more vague and indeterminate and inexact are the messages which stimuli carry to the central nervous apparatus. Thus, for example, in stimulation of the lower and posterior portions of the nasal cavity the sensation of irritation or hurt is, in many cases, referred not to the nose itself, but to the larynx, and in some instances to bronchial tubes, producing in the one case cough and in the other bronchial wheezing. This is not only experimentally but clinically true. Now in calling attention many years ago to a special sensitiveness to certain reflex producing impressions in the nasal mucous membrane, I did not, nor do I now, as has been wrongly inferred, desire to maintain that pathological reflexes may not originate from other portions of the nose, for wherever there is a sensitive nerve filament it is possible to provoke a reflex movement.

My contention is simply this: that the area indicated in my original paper represents by far the most sensitive portion of the nasal cavities, and that pathological reflex phenomena are in the large majority of cases related to diseased conditions of some portion of this sensitive area. That all pathological nasal reflexes arise from irritation of this particular area is a preposterous proposition which I do not and never have maintained. Whether a special sensitiveness in certain portions of the nasal mucous membrane exists or not, the agitation of the question has led to more rational methods of procedure in the treatment of a large class of nasal affection and to more conservative methods in intranasal surgery. Before the location of the sensitive area or areas, the nasal tissues were destroyed with an almost ruthless recklessness that bade fair to bring intranasal surgery into the worst repute. (For an elaborate discussion of this whole subject, see article by the author in Wood's Reference Handbook of the Medical Sciences, edited by Buck, Wm. Wood & Co., New York, 1887, Vol. V, pp. 222-242.)

aspect of the subject, and in the presence of that overshadowing conundrum the treatment of the condition was lost, while many followed the ancient advice of Marcus Aurelius Severinus, who declared that, inasmuch as the distorted septum was doubtless placed in that position by the will of God, it would be eminently sacrilegious to interfere with such conspicuous manifestation of Divine Dispensation, and therefore it should be left severely alone.

The measures then in vogue were the Blandin artificial perforation, a mischievous and lazy performance; the Adams' operation, the forcible restoration of the septum to the middle line with forceps, a very unsatisfactory and clumsy undertaking; stellate fracture, commonly known as Steele's, and later as the Asch operation, and the saw. Let me stop right here to do a dead man historical justice. The principle involved in the stellate fracture originated with James Bolton of Richmond, Virginia, who many years before described his method of procedure in the *Virginia Medical Monthly*. Bolton first employed an ordinary pair of button-hole scissors, with which he made the stellate incisions. Subsequently an instrument was made for him by Tiemann of New York, and from this developed the apparatus used at the present day.

Later the introduction of the surgical drill, first driven by the dental engine and afterwards by electric power, marked a decided advance in surgical procedure. With the arrival of other and newer methods this excellent agent fell into underserved neglect, in spite of the fact that a variety of work, and delicate work, can be successfully done with it without interruption of the duties of the individual, and without disagreeable after-results.

But in spite of these improvements in the surgery of the septum there were cases which still baffled the most ingenious methods. This was particularly true in regard to irregularities in the conformation of its bony framework, as in certain cases of deep-seated deflection in which the patient would not submit to operation or the surgeon hesitated to perform it. To overcome this difficulty I proposed in 1882, at the annual meeting of the Virginia State Society, and carried out in the spring of the following year, 1883, an operation which consisted essentially in the removal of portions of the external wall, and notably the inferior turbinated bone of the obstructed side (or portions thereof) as a substitute in suitable cases, for operation upon the septum itself.*

The method is applicable in cases in which sufficient reason exists for not operating on the septum. Its principle may also be extended in its application to other surgical procedures within the nasal passages. Its chief value is in certain exceptional cases in which other methods are contra-indicated or can be carried out only with difficulty.

Since my original article was published, I have received several communications from various laryngologists in this country, notably from the late Jarvis, and Roe, of New York, in which they have stated that the principle had not only given them great

*On Removal of the Inferior Turbinated Body of the Obstructed Side as a Substitute for Operation on the Deflected Septum in Certain Cases. *New England Medical Monthly*, 1884. IV, p. 249.

satisfaction, but had also extricated them on more than one occasion from great difficulty and embarrassment.

The crying need in operation on the septum is greater simplicity of performance. With a comparatively speaking small armamentarium, backed by a *quantum sufficiat* of good, common, surgical horse sense, the surgery of the septum is not a complicated problem, but one which can be worked out with comparative simplicity and satisfaction.

Such was the state of the question 33 years ago. You know its subsequent history. I will not, therefore, carry you any farther into paths which are perfectly familiar to you, and will leave you now with this brief review of the older methods, bidding you remember that it is a long, long way from button-hole scissors to the complicated technique of submucous resection, and asking you to graciously accept this little bit of personal experience and reminder of what we had to contend with in the earlier days from one who has traveled through the dust and heat of that road.

At a banquet held several years ago by the American Laryngological Association, the toastmaster, Kelly Simpson, in calling on Bosworth for a speech, said that his (Bosworth's) saw would be still on deck long after the swivel-knife had been forgotten. While this may sound to some as the irresponsible language of post-prandial enthusiasm and exaggeration, at the same time it may well come to pass that in some cases we will return to some of the older methods, or modifications of older methods, which, though less spectacular than most of those performed at the present day, did very much less harm.

The elder Disraeli, in the preface to his "Amenities of Literature," says that to be ignorant of all antiquity is a mutilation of the human mind. It has long been my custom when seeking something new to go to the ancients. So in the rush of modern invention and procedure it may sometimes be wise and profitable to pause, retrace our steps, and pass in review the work of those who have gone before. We of this generation may in this way learn much from those who, in the grey dawn of its earlier history, fought the battles of laryngology to make its calling and election sure in the eyes of their fellow-men.

In this rambling, disorderly, crazy quilt talk which I have given this little family gathering here assembled, I have endeavored in an informal way to recall some of that past, to remind you that all things did not go very well then; that difficulty after difficulty had to be met and surmounted; that the distrust in which our calling was held in many quarters had to be overcome, and that finally the laryngoscope had to be brought from its lowly place as a simple means of examination to occupy its now recognized lofty position as an instrument of progress and power in medical research, in scientific expansion and in the exploration of the unknown. The men of those days lived in a time of crisis. Laryngology was on trial, its fate was hanging in the balance. An obsession or madness such as some that have since swept through the specialty would have turned the scales, for the serpent of Esculapius

had not then been driven from the temple by the Golden Calf. Remember, too, that in that day the earnest seeker after truth had to reckon not only with his brother in regular standing, but also with the charlatan and the professional quack. It was this latter gentry's quickening opportunity and appointed time; for in the darkness and mystery of an incompletely explored terrain they found their Canaan, and in that promised land their fields of gold. Medical men confounded them with the struggling laryngologists, whom they looked upon with suspicion, and spoke contemptuously of his limited sphere of work, quite forgetful of the fact that their own ignorance of the subject was abyssmal, that their sole weapon for the conquest of throat disease was the probing, and that they were long unwilling to let even that frail scepter of their power, or impotence, pass to other hands.

I have tried this evening to live only in the past; to forget the present with all its wealth of marvelous achievement; to call back a part of the practice of a rugged era, some of which deserves to outsleep Endymion in oblivion, but much of which was most wholesome and good; to breathe again the purer and the happier atmosphere of that era, and to snatch from it, perhaps, some lost ideal; to roam once more through pleasant fields, wild and uncultivated maybe, but which loving recollection has forever kept full of fragrance, even though the budding hope of laryngology had not then come to flower.

ADDENDUM.

The equipment of the medical student is not complete without some knowledge of the past history of his art and the names, the personalities, the aspirations, the ideals, the lives and deeds of those who made it. It is an amputation of his mind to cut it off from the wondrous story of the birth and growth and development of medicine and its compelling progress in all the ages, through storm and sunshine, through error and enlightenment, through failure and achievement. And if he goes at it in the proper way, its study will not be labor, but will bring to him the most satisfying mental relaxation and the most refreshing consciousness of culture that cannot be obtained in any other way. In the short sketches which follow I have given a few brief references to the work of some of the men whom every student of rhinology should know something about.

Jean Fernel, or Fernelius, as he is known to the medical historian, was born in Picardie (1360), but later moved to Paris, where he acquired a large practice and became body physician to Henry II, then King of France, whose sterile wife, the notorious Catherine de Medici, was made to bear offspring through his skilful treatment, a service which so pleased the monarch that whenever he left home he always took Fernelius with him. On one of these excursions the physician's wife was taken suddenly ill with a cold and died, and her husband's grief was such that he followed her soon afterwards to the grave. Catherine had a number of children, among them two daughters—Elizabeth, who married Philip II of Spain, and Margaret of Valois, who married the King of Navarre—and a son, Henry, who ascended the throne as King Henry III. It is interesting in this connection to recall the anecdote of the latter at the betrothal feast of his sister, Margaret, as an historical example of the power of olfactory impression in awakening sexual desire. On that occasion he dried his face, by accident, with a garment, moist with her perspiration, belonging to Maria of Cleves. This so excited him sexually that, although Maria was then the bride of the Prince of Conde, he could not restrain his passion, and made her miserable, as history tells us. A similar story is told of Henry IV and the

beautiful Gabriel, who later became his mistress, the King's desire being aroused when at a ball he wiped his wet brow with her handkerchief.

Fernelius was a prolific writer, but among his services to medicine he should be remembered by laryngologists in general and students of sinus disease in particular as the keen observer, who a century and more before Schneider wrote, with the ancient doctrines of the Greeks and Arabians still unchallenged, and 400 years before our own time drew, unconsciously perhaps, a subtle distinction between suppuration from the "pituitary" sinuses or thereabout and the purulent flux which was supposed to come from the cavity of the cranium.

Gabriel Fallopius, 1523-1502, famous anatomist, whose name survives in many parts of the body, notably the Fallopian tubes, the brilliant pupil and successor of Vesalius, should be familiar to laryngologists for having introduced the cannula in the development of the modern snare and as the alleged discoverer of the sphenoidal sinus.

Aranzi, Arantio, or Julius Caesar Arantius, a celebrated Italian physician and surgeon of the sixteenth century, wrote among other volumes a work on the human foetus and tumors, and invented a forceps for the removal of nasal polypi. He introduced an original method for the direct examination of the nasal passages. In a wooden window shutter, opening into a darkened room, he cut a circular foramen, through which the direct concentrated rays of the sun were allowed to stream. The organ to be examined (nose, ear) was thus illumined by the column of sunlight. If the sun was not shining, or if the examination took place after dark, he used a candle or, better still, a globe of crystal filled with water through which the light was made to pass, thus anticipating the so-called "Schusterkugel" method of examination of the present day by nearly 300 years.

Nathanael Highmore, an English anatomist, born in 1613, the author of books on the art of generation, hysteria and hypochondriasis, but is chiefly known to medical scholars by his work on anatomy, published in 1651 and entitled "Corporis Humani Disquisitio Anatomica," in which occurs his famous description of the antrum maxillare illustrated by a large plate with three or four figures, in which he portrays the cavity and its relation to the surrounding structures and to the brain.

The two Meibomii—John Henry and Henry, his son, the latter born in 1638 and known to anatomy as the discoverer of the Meibomian follicles in the eyelids—were among the early investigators of antrum disease, as we learn from the work of J. G. Günz (Programma Indicit et Observationem Ad Ozaenam Maxillarem Ac Dentium Ulcus Pertinentem Proponit—Lipsiae, 1753), a learned exposition of the maxillary antrum surgery of his day.

James Drake (1667-1707), an English anatomist and surgeon, chiefly remembered by his classical work on anatomy entitled "Anthropologia Anatomica," was one of the first, if not the first, to call attention to the fact that the sanies of ozoena (foetid and purulent discharges from the nose) came not infrequently from the pituitary (accessory) sinuses and more especially from the antrum.

William Cowper, an English surgeon anatomist, born in 1666, has the credit of having discovered the urethral glands (1702), which today bear his name, although they were previously found and described by Méry (1684), wrote several well-known works on the muscular system and a treatise on anatomy entitled "The Anatomy of Humane Bodies," published in 1698, which he illustrated with 105 original plates, to which he added 9 perfunctory ones of his own, which with a serene audacity which is not a stranger to some of our fellow-mortals of the present day, he bodily stole from the classical work of Bidloo (1685), a celebrated Dutch anatomist and contemporary. Cowper's service to laryngology consisted in bringing the main anatomical facts of sinus (antral) disease to light, in laying open, as it were, its pathological condition, in showing how it could be distinguished from other affections, how easy is was with the aid of anatomy to apply remedies direct to the cavities themselves, and finally how readily the structures could be reached surgically, thus making a giant stride from the practice, which we learn from Celcus, came down from a remote antiquity, of cutting open the face even in cases of superficially situated ozoena and purulent discharge and sewing it up again.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor*.

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RICHARD H. JOHNSTON, M.D.

BALTIMORE, APRIL, 1916

WILL THE CLOSING OF BALTIMORE'S SEGREGATED DISTRICT RESULT IN A DECREASE OF VENEREAL INFECTION?

THERE are many advocates for the closing and as many against the closure of assignation-houses. Those for declare that venereal infections are decreased thereby; those against claim that such conclusions are misleading and fallacious. So there you are. You can take your pick. However, the researches of Dr. A. R. Warner, as published in the Cleveland *Medical Journal*, lead us to believe that the abolition of the segregated district in Cleveland has absolutely resulted in a decrease in venereal infection in that city. Though figures can be made to lie, and, in many instances, prove but little, still one cannot help but be convinced that syphilis has been lessened by these measures. For the eight months preceding the closing of these houses 112 cases of syphilis, in which full data could be obtained, were treated in the Lakeside Dispensary. In comparison with these figures, the first eight months following the closing of the segregated district produced only 18 cases of syphilis for treatment in the Lakeside Dispensary. If there was such a falling off in the number of luetics presenting themselves for treatment in a dispensary of the character of the Lakeside, it is only fair to conclude that these figures are approximately correct for the entire city, and might justly serve as an index. It may, therefore, be assumed that this comparison is a fairly accurate picture of the public health as respects syphilis before and after the closing of the segregated district. With the vice district in operation 112 cases presented themselves for treatment; with it closed only 18. Surely if a law operates to produce

such a falling off in a disease so fraught with suffering, both bodily and mentally, it is impossible to calculate or even to realize the blessings resulting from its creation. If the closing of the vice district in Cleveland has operated so excellently in decreasing luetic infection, there is no reason why the same results should not obtain in Baltimore. If morphine could be obtained at every corner grocery store, there would be more morphine addicts than there are under the present stringent restrictions as regards the obtainal and disposal of this drug. So, if the bawdy-house is easily accessible to the young man and youth of the city and surrounding districts, naturally they will, when occasion presents, seek them out for their nefarious practices. If the plying of the trade by inmates of houses of prostitution, rooming-houses and street walkers is proscribed by law, then the opportunity of those desiring such associates will be materially diminished, and it seems reasonable to expect under such conditions a falling off in the amount of venereal infection. At any rate, such has apparently proven to be the case in the city of Cleveland; the same happy results should follow the closing of the Baltimore vice district. Syphilis is a horrible infection. It causes its victims to loose all self-respect. It not only wreaks its vengeance on the original sinner, but his descendants, unborn generations thus paying the price for the waywardness of others over whom they had no control. The city, the nation, the State, the individual, one and all suffer as the result of the spread of syphilitic infection throughout the land. Surely, then, those Baltimoreans who were courageous enough to fight this canker in the body politic are to be thanked for the fight they waged and for its successful outcome. The final results will prove the wisdom of eliminating such evils from the city. The law has proven already its value in Cleveland, and when similar results are published from Baltimore the good people will come to a thorough realization of the debt owed the agitators and reformers, dreamers, if you care, who doggedly and steadfastly stuck to the job and once and for all time drove harlotry out of the city.

Medical Items.

The complimentary dinner which is to be given Prof. Randolph Winslow in commemoration of the completion of his twenty-fifth year as a member of the Major Faculty of the University of Maryland Medical School, will be held at the Hotel Belvedere, on Monday, May 8th, at 8.30 P. M. The committee on arrangements is composed of Drs. William P. Stubbs, chairman; Arthur M. Shipley, William Tarun, G. Milton Linthicum, Alexius McGlannan, Fred W. Rankin and Elmer Newcomer.

Dr Everett Le Compte Cook, who for the past two years has been resident at the Municipal Tuberculosis Hospital, will soon enter private practice.

Dr. J. F. Byrne, who assumed the duties of health warden of the Fourth ward, February 1st, has resigned from the City Health Department. He will resume his former duties as a member of the medical staff of the Baltimore and Ohio Railroad. Dr. Byrne was appointed to succeed Dr. H. K. Gorsuch, resigned.

In order to study the latest methods in hospital management and in the conduct of clinics, Dr W. F. Mayberry and Dr. E. B. Echlin, of Ottawa, Canada, spent a few days at the Johns Hopkins Hospital. They stopped at the Belvedere Hotel.

Dr Joseph C Bloodgood held a cancer clinic at the University of California Hospital, San Francisco, March 31st, under the auspices of the California Academy of Medicine.

Dr. Raymond L. Johnson, of the resident staff of the University Hospital, tendered his resignation March 31, to accept a position with the Atlantic Coast Line Hospital, Waycross, Ga.

At the session just ended, the Maryland Legislature created a commission to be known as the Washington Suburban Sanitary Commission, to study the matter of water supplies and drainage systems for the sections of Montgomery and Prince George's counties, bordering on the District of Columbia. The commission is authorized to negotiate with the proper authorities of the District with reference to the connection of the proposed county sewerage system with the sewerage system of the district.

In September another step forward will be taken by the Johns Hopkins Medical School, when the immunologic department of the school will be opened. This department will occupy the fifth floor of the new Hunterian laboratory building, which is in the course of construction. The medical school has had an immunologic department in the past, but it has never been developed in the manner in which those in charge of it desired. The main purpose of the building will be to afford opportunities for bacteriologic study, particularly in connection with post-mortem examinations.

Dr. J. McPherson Scott has been re-elected mayor of Hagerstown for the fourth consecutive term.

Dr. Charles W. Mitchell, who has been seriously ill with pneumonia, is improving steadily.

Dr. Henry Mills Hurd gave a dinner at the Maryland Club recently to the members of the Board of Trustees of the Johns Hopkins University and a number of prominent physicians of the city, to mark the fiftieth anniversary of his graduation in medicine.

The Nurses' Training School of the Maryland General Hospital, held its annual commencement at 3.30 o'clock on the afternoon of April 18, at Lehmann's Hall. There were fourteen graduates, comprising the largest class ever graduated from the hospital. Following the exercises the graduates were guests of the Nurses' Aid Committee at a banquet at the Rennert Hotel.

The first joint meeting of the Baltimore City Medical Society and the Medical Society of the District of Columbia was held at Osler Hall, April 7, at 8.15 P. M. A smoker was held in honor of the Washington guests immediately after the meeting.

We are pleased to announce that Dr. Frank W. Keating, superintendent of the Maryland Training School for Feeble-Minded Children, Owings Mills, Md., who was operated on recently for gall-stones and chronic appendicitis at the University Hospital, is rapidly convalescing.

Dr John M. T. Finney delivered the fifteenth Rush Society Lecture in lecture room B, of the medical laboratories of the University of Pennsylvania, April 6, on "What Constitutes a Surgeon." This lecture is also the annual address before the Undergraduate Medical Society of the University of Pennsylvania.

The Skin and Cancer Hospital has moved into its new home on Greenmount avenue. The buildings are large and the grounds ample for

the accommodation of the patients. The work of the hospital is almost entirely charitable, and treats a class of patients not usually received in other hospitals. The establishment of a free dispensary in connection with the hospital is proposed at an early date.

Dr. Howard D. Lewis announces the removal of his offices to the Normandie Apartments, 2000 block St. Paul street, first floor. Office hours, 9-10 A. M. and 7-8 P. M. Phone, Homewood 1400.

Dr. Harry F. Shipley, Granite, Md., who has been under treatment for kidney trouble at the Mercy Hospital, is very much improved.

ENGAGEMENT

The engagement is announced of Dr. M. L. Lichtenberg, University of Maryland Medical School, '12, for several years resident physician of the University Hospital, now practicing at 1038 N. Monroe street, to Miss S. S. Sagner, of 2555 McCulloh Street. Dr. Lichtenberg has done much and varied work in the different specialties, and great things are expected of him, his friends believing he will be very successful.

MARRIAGES

Austin H. Wood, M.D., University of Maryland Medical School, '14, of Baltimore, Md., to Miss Zelda Treece, of Shy Beaver, Pa., at Shy Beaver, March 16, 1916.

Arthur L. Fehsenfeld, M.D., University of Maryland Medical School, '09, to Miss Doris V. Thomas, both of Forest Park, city, at Forest Park, April 1, 1916. Immediately following the ceremony, Dr. and Mrs. Fehsenfeld left for a tour of the North.

Grover Augustus Stem, M.D., University of Maryland Medical School, '12, of Westminster, Md., to Miss Irene Miller, of Baltimore, Md., at Baltimore, in September, 1914.

Lewis A. Sexton, M.D., Vanderbilt University Medical Department, Nashville, Tenn., '00, of Baltimore, Md., formerly of New York, second assistant superintendent of Johns Hopkins Hospital, to Miss Henrietta Stenz, of New York City, at New York City, April 10, 1916. Dr. and Mrs. Sexton will make their home here at the Tudor Apartments, Baltimore.

DEATHS

Dixie Montgomery Muncaster, M.D., University of Maryland Medical School, '66, of Washington, D. C., died at his home in the Bracon Apartments on or about April 2, 1916, following a short illness, aged 73 years. For the past 45 years, Dr. Muncaster had been practicing in Washington and was in active practice until five days before his death.

Edward Wachtell Palmer, M.D., Baltimore Medical College, '02, of Greencastle, Pa., a member of the Chambersburg Hospital staff and Franklin County Medical Association, and president of the Greencastle School Board, died in the Chambersburg Hospital, April 17, 1916, following an operation for appendicitis, aged 46 years.

George A. Strauss, Sr., M.D., College of Physicians and Surgeons, '83, of 13 East Montgomery street, Baltimore, Md., died at his residence after a long illness from heart disease and dropsy, April 5, 1916, aged 59 years. Dr. Strauss was not in active practice, having retired three years ago.

Thomas Hugh O'Connor, M.D., College of Physicians and Surgeons, '93, of Roxbury, Boston, a Fellow of the American Medical Association; for ten years police surgeon at Roxbury Crossing, Boston, and since 1911 a school physician and medical inspector in the Division of Communicable Diseases of the Department of Health; for several years a member of the staff of the Children's Hospital; fell on the ice near his home March 19, sustaining a fracture of the skull, and died from cerebral hemorrhage March 30, 1916, aged 49 years.

Emory Burr Huyck, M.D., Baltimore University School of Medicine, '95, of Oak Harbor, Ohio; a Fellow of the American Medical Association; coroner of Ottawa County, Ohio; for fifteen years local surgeon of the Lake Shore and Michigan Southern Railway, and chief surgeon of the Toledo, Port Clinton and Lakeside Company; health officer of Oak Harbor for twenty years; died at his home, March 20, 1916, from nephritis, aged 53 years.

Robert S. Hart, M.D., Washington University School of Medicine, Baltimore, '09, of Pisgah, Ky., a member of the Kentucky State Medical Association; a Confederate veteran; for more than forty years a practitioner of Fayette and Woodford counties; died at his home, March 21, 1916, from heart disease, aged 72 years.

Robert H. Hoge, M.D., College of Physicians and Surgeons, '73, of Hoge's Store, Va.; for many years chairman of the Board of Health of Giles County, Va.; died at his home, March 7, 1916, aged 64 years.

ATTENTION, THE S. P. C. S.!

The Federal Trade Commission has sent to Congress a preliminary report on the rise in the price of gasoline. It draws no conclusions, but presents masses of statistical information. Among the items noted in the press summary are:

Production of crude oil remained virtually stationary; gasoline contents of crude oil decreased; exports of gasoline increased from 188,000,000 gallons in 1913 to 238,500,000 gallons in 1914 and 284,500,000 gallons in 1915; for its 62 per cent. of the gasoline produced the Standard Oil Company charged about 1 cent a gallon less than the "independents" charged for their 38 per cent.

The last item ought to move the Society for the Prevention of Cruelty to Statesmen to do something. Consider the hard lot of the member of Congress with a large constituency of automobile owners. Confronted with angry complaints about the "high price of gas," he is deprived of his old familiar explanation.

He cannot dismiss the complaints with the classic vituperation of the "trust"—the "octopus"—for here is the Federal Trade Commission with its cold-blooded price tables! Truly, the way of the statesman who deals in oratory meant only "for Buncombe County" grows harder every day.

WILLS HOSPITAL OPHTHALMIC SOCIETY.

Meeting of October 4, 1915.

Dr. McCluney Radcliffe, Chairman.

Dr. William Campbell Posey exhibited the following:

1 *A Case of Traumatic Ptosis Operated on by the De Wecker Method.*

The patient, a young man, had had the left upper lid torn away by a steel hook. When first seen after the accident, all but the outer third of the lid was evulsed. His family physician had sewn the lid roughly into position directly after the accident, but when first seen by Dr. Posey the lid was a shapeless mass, hanging down and over the lower lid. Dr. Posey's first procedure was to cut away all superfluous cicatricial and granulation tissue, and to reunite the edges of the wound. After the healing due to this had been effected, the lid was raised by a Tansley-Hunt operation. On account of the injury to the tissues, this operation was only partially successful, the width of the palpebral fissure being but 4 mm., so a De Wecker operation was done, the subcutaneous stitches being held in position for two weeks. The ultimate effect was excellent, the fissure being now 7 mm. in size. It is thought that the effect of the operation will be increased as time goes by, as the subcutaneous cicatricial bands produced by the sutures contract.

2 *Exhibition of a Case of So-called "Juvenile Glaucoma."*

The patient, a young man 22 years of age, without any family history pointing to glaucoma, had gradual loss of vision in each eye for a year or more. Examination showed atrophic nerves with deep glaucoma cups. Tension equalled 28 in each eye. The form fields were much contracted and the color fields obliterated. Vision was reduced to 2/40 in each eye. Iridectomy was performed on both eyes under ether, with resultant 4/40

vision in each eye. Dr. Posey thought the etiological factor was probably alcohol, as the patient confessed to taking four or five drinks daily for six years or more. There was also a possibility of his having taken wood alcohol. Dr. Posey believed the glaucoma to be really an instance of the secondary type of this disease, the glaucoma cups having originated in consequence of the softening of the optic nerves from the alcohol, and perhaps an accompanying low-grade uveitis due to the same causes, which had produced a blocking of the posterior lymph passages of the eye.

3. Deformity of the Right Upper Lid Due to Traumatism.

Dr. Posey exhibited a case of deformity of the right upper lid in a young man which he had corrected by a blepharoplasty. The deformity was the consequence of a kick upon the orbit. The inner canthus of the right eye had been contracted downward and somewhat outward, so that the upper lid assumed the appearance of a very broad epicanthal fold. The canthus was placed in the proper direction by incising the scar tissue and sewing it in the position normally occupied by the palpebral ligament. The broad epicanthal fold was narrowed by excising a semilunar strip of skin. Healing was prompt, and the deformity caused by the accident almost entirely corrected.

A Case of Pigmentary Degeneration of the Retina Complicated by Acute Glaucoma.

Dr. William Zentmayer showed a case of advanced pigmentary degeneration of the retina in a woman 58 years of age. There was a posterior polar subcapsular opacity in the lens. The unusual feature in the case was a high degree of sclerosis of the choroidal vessels. Vision in the right eye equaled 6/24; in the left there was merely light perception. The field in the right eye showed concentric contraction to within 15 degrees of fixation. One week before coming under observation she had had an attack of acute glaucoma, which was aggravated by the use of atropin by her family physician. The eyeball was stony-hard, and all the other phenomena of suddenly increased intraocular tension were present. Trephining of the sclera, combined with a small peripheral iridectomy, was done. The tension three weeks after the operation was still below normal. The patient recognized hand movements at 1 m. Glaucoma as a complication of pigmentary degeneration of the retina has been observed several times. Instances have been put on record by Heinrichdorf, Bellaminoff and others. Both chronic and acute types have been seen. The reason for the rise in tension has not been determined. In the above case it is probable that the high-grade sclerosis of the choroidal vessels was a factor. A sclerosis that had affected more largely the vorticose veins than the arteries would explain the attack of glaucoma.

A Case of Buphthalmos Benefited by Tuberculin.

This case was presented by Dr. J. Milton Griscom, who said that the patient, a girl of 12 years, had applied to Wills Hospital for treatment August 27, 1915. Vision in the right eye was 8/200. Blepharitis marginalis and interstitial infiltration of the cornea were found, with a central macula (1 mm.) and some

vascularity. The anterior chamber was somewhat deepened. The iris was normal, and the pupil reacted promptly. No fundus details could be seen. In the left eye there were light perception and projection. Buphthalmos was present. The cornea was large, with a central macula (3 mm.) and some vascularity. There was marked interstitial infiltration. The anterior chamber was deep. The iris was normal in color and 13 mm. wide. The pupil was sluggish. No fundus details were visible. There was slight scleral injection, also ciliary stretching. The tension equaled 43 mm. mg. Blepharophimosis was present, with slight roughness of the conjunctiva. There was also lachrymal obstruction. The urine was negative. The family physician stated that the condition has existed for nine years. He thought that it had followed an attack of measles complicated with a tubercular element. The patient's father had died of tuberculosis, and her cervical glands were enlarged. The attack of measles occurred nine years before admission. She had been treated by various oculists at a New York hospital, with no improvement in the condition of the eyes. She was admitted to Wills Hospital on the 3d of Septmber, and was operated upon under ether, an external canthotomy with rapid dilation of the tear duct being performed on both eyes. The Von Pirquet test was positive. Ten injections of tuberculin, 1/50 mg., were given, and 10 injections of phylacogen, 2 c.c. The house tonic was prescribed. Eserine, gr. j, was instilled into both eyes. The ocular condition gradually improved, and also the general health. Both cornea became clearer, and the left globe perceptibly smaller. There was a slight reduction in the size of the cornea and the depth of the anterior chamber. When discharged, November 10, the iris was 12 mm. wide, and the corrected vision as follows: Right eye, sphere plus 2.25 equals 20/70; left eye, sphere minus 0.75 D combined with cylinder minus 1.25 D, axis 30 equals 20/100.

A Case of Proptosis Due to an Orbital Tumor.

Dr. James Hunter, Jr., presented this case. The patient, a married woman 47 years old, had had, in September, 1913, an attack of severe pain over the left eye, associated with headache. The attacks would commence in the morning, reaching their maximum intensity about 9 A. M., and would compel the patient to take to her bed. The pain would last until about 4 P. M., when it would ease enough to permit her to resume her usual work. She had sought medical advice, with little or no relief, the pains becoming steadily worse. In August, 1914, there was pain, confined to the globe. The eye began to swell, and there was marked edema of the lids. The latter was at first relieved by cold compresses, but soon became permanent. The patient applied for treatment May 24, 1915, with much the same appearance as she presented when exhibited by Dr. Hunter at this meeting, but the globe was then not quite so prominent. She had ptosis, palpebral fissure at the mid-pupillary line, and a pupil of 4.5, which reacted promptly. There was diplopia on extreme upward rotation. The tumor mass above the eyeball, to the nasal side of the orbit, was more prominent when the patient was shown than it had been on admission. Examination of the fundi was negative. The tumor was apparently one of slow growth, springing from the periosteum of the nasal side of the orbit, 15x20 mm., with a soft point of

apparent fluctuation at its temporal edge. An X-ray of the sinuses was negative.

J. Milton Griscom, M.D.,
Secretary.

PNEUMONIA.

Ten per cent. of the deaths in the United States result from pneumonia. It is estimated that during the past 30 days this rate has been doubled in some sections. Tuberculosis and heart disease, each causing one-ninth of all fatalities, are the only diseases which outrank pneumonia among the legion of the men of death, but in certain cities pneumonia is steadily increasing, and even has surpassed the mortality from tuberculosis. Seventy per cent. of all cases occur between December and May. It is distinctly a cold-weather infection, seemingly brought by wintry blasts, but especially prevalent during the winter season only because its victims are rendered more susceptible at that time by exposure, debilitating influences and the presence of predisposing infections.

Pneumonia principally affects those at the extremes of life, but no age is exempt. It is invariably a germ disease. The predisposing and exciting organisms are so numerous that it would be futile to attempt their enumeration. Many of them are constantly present in the mouths and throats of healthy persons, and it is only through the aid which we unwittingly extend to them that they are transformed from harmless organisms to one of man's most powerful enemies.

The presence of other diseases is the great predisposing cause of pneumonia. They prepare the soil for invasion. Holding first rank in this category is influenza, the increased incidence of pneumonia at this time being largely due to the present epidemic of la grippe. Individuals suffering from this infection are peculiarly susceptible to respiratory complications, and should properly observe every hygienic rule. Inflammation of the upper air passages, pharyngitis, bronchitis and tonsillitis often predispose to the development of the disease, particularly among the aged and infirm. The acute contagious diseases of childhood, more especially measles and whooping-cough, frequently prepare the way for pneumonia. Anyone who, through neglect or carelessness permits the spread of these infections, is therefore open to the severest condemnation. Exhausting disease of whatever nature is often sufficient to so reduce our resistance that we are unable to cope with organisms which should be easily overcome, and hence predisposes to the infection.

Debility, either temporary or chronic, developing from any cause, increases susceptibility. Because of this the disease most often attacks those at the extremes of life. Among debilitating influences must be mentioned cold, exposure to penetrating winds and the chilling of body surfaces as a result of wetting. The combination of lack of food and fatigue proves particularly disastrous during the winter season, and is a condition to be avoided whenever possible. Bad housing, mental or physical harassment and overwork are alike the advance agents of the infection. Overcrowding in street cars, theaters and other public places is unquestionably in part responsible for the spread of pneumonia in cities, as far greater opportunity is thus offered for the dissemination of the predisposing diseases through indiscriminate cough-

ing and other means of droplet infection, as well as the directly injurious effects which inevitably result from exposure to such environment. The overheating of rooms is also seemingly harmful. Promiscuous expectoration may be, and probably is, a factor in infection, and consequently should be avoided by every citizen. A remaining most important agent should be mentioned —alcohol. It is in truth the handmaiden of pneumonia, and there is none more certain or more sure of success, especially if liberally and continuously used.

While the foregoing facts constitute in part our knowledge of the reasons for the widespread dissemination of an infection which carries with it a mortality or from 10 to 30 per cent., it should be remembered that our scientific data are not yet complete. There are problems connected with immunity, predisposition and the occurrence of epidemics which are yet to be solved. It is known that pneumonia frequenty attacks those who are perfectly well and who apparently have observed every hygienic rule. Whether this is due to the increased virulence of the organism or to other causes is unexplained. It is, however, recognized that avoidance of the factors so briefly enumerated will in large part diminish individual susceptibility, and therefore the incidence of the disease.

THE COMING OF PEACE.

The writer has made the prophecy that peace will come in Europe before snow flies again. You see, he is a brave man! But there are many signs and rumors, showing that the people of the nations engaged are getting thoroughly tired of destroying one another; and it requires no great perspicuity to discover that if the contest continues many months more their resources in men and wealth will reach a perilously low ebb. And for what? Probably nothing, or nothing worth while. The war promises to end in a deadlock—a stalement. Great conquests, or the suppression of smaller nations, or the "crushing" of the enemy by either side would meet the moral condemnation of the entire neutral world, and would leave behind a stain from which the "victor" would never recover.

Why cannot the neutral nations of the world, headed by our own administration, be preparing and working now for peace? The time may not be ripe for a peace congress, but it is certainly most desirable that those who can still reason calmly about this war should be discussing methods of settling it in such a way that the awful crime should never be repeated.

To bring about a permanent peace—or one that can give some promise of permanency—two things seem essential. The first is that the burden and the threat of militarism shall be lifted, by general agreement, by all the nations of the world. The second is that justice shall be done to every oppressed people, new treaties being written with the understanding that every government obtains its just power "from the consent of the governed."

Is it not a good time for the neutral nations to be uniting for support of these two principles? What reason in morals or sound economics can any of the belligerents find for opposing them? Deliberate aggression and imperialistic ambition, whether English, Russian or German, have been shown by the experience of the last two years to be deliberate suicide.

Publishers' Department.

Danger Due to Substitution.

HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

"Spring Tonics."

IN the good old days it was thought that winter left everyone run down and in urgent need of a tonic, and the ingenuity of the doctor as well as housewife was drawn upon to provide a tonic that would be potent as well as palatable. But today the skill of the manufacturing chemist has made it possible to employ that best of tonics, cod liver oil, in the spring, summer and whatever other seasons the patient may demand it. In the form of Cord. Ext. Ol. Morrhuae Comp. (Hagee) the profession has at its command a palatable cod liver oil preparation that introduces into the system the every nutritive quality of the crude oil.

The After Care of Children's Ills.

WITH the advent of schooldays and the daily association of many children in the classroom, the contagious diseases of childhood develop and multiply. The exanthemata, as well as diphtheria, whooping-cough, etc., comprise a considerable proportion of the diseases that the family physician is called upon to treat during the late fall and winter months. The robust child, with but a mild infection, frequently recovers quickly, and perhaps requires but little attention during the convalescent period, while the child whose general nutrition is "below

par" usually emerges from the acute attack with a condition of anemia and general vital depreciation. In the large majority of cases it is undoubtedly wise to encourage and hasten convalescence by means of a palatable and efficient hematinic and general tonic. For this purpose Pepto-Mangan (Gude) is especially valuable. All children like it and take it readily; it does not irritate the digestive organs, but, to the contrary, increases the appetite and assists in the absorption and assimilation of the child's nourishment. As it is non-astringent, it does not, as other ferruginous remedies do, cause or increase constipation. As Pepto-Mangan is prompt and efficient as a blood builder and general reconstructive, it should be preferred among children whenever medication of a general tonic nature is indicated.

The Opium Habit.

Since the passage of the Harrison act the management of opium habitues has been a problem with the profession. Various agents have been employed for the purpose of adding to the victim's moral resistance, and to take the edge off of the inordinate craving for the accustomed narcotic.

It has been found by a large number of physicians that nothing seems to exert such a beneficial influence on opium fiends as PASADYNE (Daniel), and it is recommended in every instance of addiction.

PASADYNE (Daniel) is simply a concentrated tincture of passiflora incarnata, and has a powerful influence over the higher centers. As a calmative, especially in women, PASADYNE (Daniel) is of the highest worth. Besides its marked therapeutic power, it has the further advantage of innocuousness. Sample bottle by addressing laboratory of John B. Daniel, Inc., Atlanta, Ga.

Silvol: A Notable Germicide.

For application to mucous surfaces as a germicide silver nitrate has long been recognized as a distinctly meritorious agent. It has had one serious drawback, however—its use in solution frequently caused irritation. Finally, as was to have been expected, the art of the chemist has overcome this objection. The combination of silver with a proteid base robs the former of its irritating effect. At the same time there is no loss of antiseptic value.

A proteid-silver preparation that is meeting with marked favor by eye, ear, nose and throat specialists as well as by specialists in genito-urinary diseases is offered by Parke,

Davis & Co. under the name of Silvol. That this product has a number of advantages over most of the silver salts hitherto used is evident from the numerous commendatory references to it that are finding their way into the medical press. An article in point has just come under the eye of the writer, and is worth noting in this connection. It appears in the December issue of the *Journal of Ophthalmology and Oto-Laryngology*, and is from the pen of William C. White, D.D.S., Ph.G., M.D., of the University of Louisville.

Dr. White describes Silvol as "a metallic silver in colloidal combination with a proteid base, and slightly alkaloidal in reaction. It occurs in black, metallic, lustrous scales, slightly hygroscopic and very readily soluble in water. In solution it gives a rich seal brown color and produces only a temporary stain to clothing or dressing, which is completely removed by rinsing in warm soapsuds. The preparation is so soluble that it requires only a moment to make the necessary solution. It is practically non-irritating in any reasonable dilution. The solution does not require filtering, and I wish to emphasize this fact, as it has been my experience with other similar products, especially in heavy solution, that a tarry substance will appear upon the surface, and, unless this is filtered out, it produces more or less irritation to the sensitive mucous membranes upon drying, leaving a very disagreeable burning or smarting sensation to the parts. None of my patients complained of pain or showed any irritation when a 10 per cent. solution was used; on the contrary, they have expressed a feeling of comfort and a soothing sensation immediately following the application."

In summarizing, Dr. White names these advantages as applying to Silvol: "Quick solubility in any solution necessary for application to mucous membrane; less staining than by other proteid silver preparations; high percentage of silver content; minimum amount of irritation when applied to mucous surface; low percentage solutions necessary as compared with other similar preparations."

Silvol is supplied in powder (ounce bottles) and in 6-grain capsules (bottles of 50). The contents of two capsules make one-fourth ounce of a 10 per cent. solution. Silvol Ointment (5 per cent.), for application to regions where the use of an aqueous antiseptic solution is not feasible, is also offered. This ointment is marketed in long-nozzled collapsible tubes, two sizes, designated as large and small.

The "Improved" Angier Atomizer.

THE Improved Angier Atomizer is a simple, sanitary, 2 in 1 Atomizer that meets a universal requirement. Its simplicity and cleanliness cannot help but appeal to the most fastidious. It is especially adapted for use in either throat or nose troubles and fits the nose of everyone perfectly, even the smallest child. It can also be used for treating the back of the throat, as needed in treating sore throat, tonsilitis, diphtheria, bronchitis, catarrh, etc.

The Therapy of Neurotic States.

THE bromides have served no more useful purpose than in those unstable nervous states so frequently met with in women, and yet owing to this very instability their administration must be supervised with the greatest care if the patient is to be guarded from the disadvantages which accompany the use of these salts.

The fact that BROMIDIA (Battle) represents the therapeutic height of the bromides and is free from their disagreeable side-effects

has made this bromide preparation a great favorite in the treatment of female neuroses.

From it may be expected the full therapeutic effect of the bromides, with the further advantage of freedom from the untoward effects of hastily-prepared bromide mixtures.

Gastric intolerance is obviated by the extreme care exercised in choosing the contained drugs in BROMIDIA (Battle) and in compounding them.

When the Physiologic Processes of the Bowel Need Stimulating.

IN this day of extremes the practitioner must not let the success obtained in certain cases of bowel stagnation, by the use of "intestinal lubrication," blind him to the fact that paraffin oil is essentially restricted in its indications. To employ it indiscriminately in all cases of constipation means complete failure to get results in many instances—and the consequent discrediting of a remedy of undoubted value when properly used.

As a matter of fact, in a large proportion of cases of constipation there is atonicity of the muscular coat of the intestines, together with marked decrease of glandular activity. Measures to impart tone to the bowel musculation and increase the glandular secretions are therefore imperative, and no remedy has been found more effective for these two main purposes than Prunoids. This has proven itself a true corrective of constipation of functional origin, its effect on the physiologic processes of the bowels not only assuring a prompt restoration of intestinal activity, but with gratifying freedom from all griping or reactionary constipation. The most casual test will show Prunoids to be a true physiologic laxative that can be used with every confidence in the permanency of its benefits.

PYORRHEA is gradually being recognized as the causative agent in many pathological conditions which long baffled the medical practitioner. Physicians who formerly looked past pus-containing spongy gums to a more or less normal pair of tonsils are focusing their diagnosis on lesions about the teeth. In their early incipiency these lesions are hard to recognize, and are frequently missed even after an examination by the dentist. While the abscesses may be very minute, their growth is gradual, and they continue to furnish a certain amount of toxic material day after day. The patient may never complain of trouble about the teeth, and the condition gradually grows worse until the teeth become loose and painful.

It is now known beyond any doubt that pyorrhea is the causative factor and the primary focus of infection in many cases of systemic disease.

With the knowledge now available to the physician concerning the etiology of pyorrhea, and a means of administering the ipecac alkaloids by mouth in large doses without nausea by means of Alcresta Tablets of Ipecac, it is entirely within the bounds of reason to expect many startling results from the use of the alkaloids of ipecac in complications that have stubbornly refused to yield to medical treatment.

It is, however, quite essential that the physician co-operate with the dentist, and vice versa, as best results in the treatment of both pyorrhea and the conditions accompanying the disease will be secured only if proper attention is given both to constitutional and local dental treatment.

The Liver in Autotoxic Ills.

THE liver, as the largest gland in the body and the one that is called upon to do the most work, is to a certain extent both the "clearing-house" and the "depository" of the body's nutritional reserve. It is easy to understand, therefore, how even a slight disturbance of its functions may be followed by serious consequences throughout the whole organism.

Realizing this, it is little wonder that the trained clinician is so keen and prompt to take steps to prevent the continuation of hepatic derangements. Undoubtedly it is zeal in this direction that has led so many physicians to prize Chionia, for they have found it a remedy that can be relied upon not only to restore and maintain hepatic activity, but happily without exciting excessive or objectionable bowel movement. The exceptional therapeutic efficiency of Chionia, therefore, in all functional disorders of the liver has made it one of the most valuable and practically useful remedies at the command of the practitioner who realizes the paramount importance of assuring hepatic activity, especially in ills of an autotoxic character.

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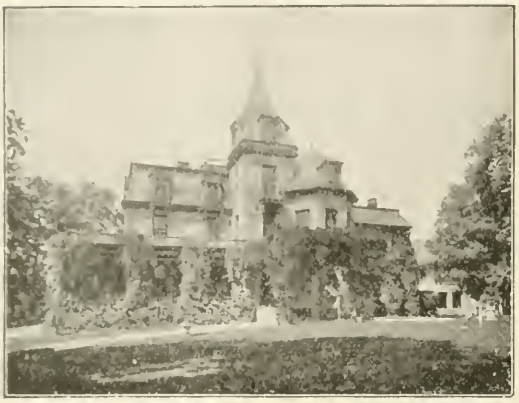

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